

WHEN DOES MNRO APPLY?

The MNRO law is applicable when a covered person receives an adverse determination based on medical necessity on a service that is otherwise payable under his or her policy or certificate of coverage sold in Louisiana.

WHEN DOES MNRO NOT APPLY?

1. The MNRO law **does not apply** when the health care service in question is **not** a benefit that is covered and payable under the policy or certificate of coverage.
2. The MNRO law **does not apply** to limited benefit plans, workers' compensation, or self-funded ERISA-qualified health plans.

Louisiana

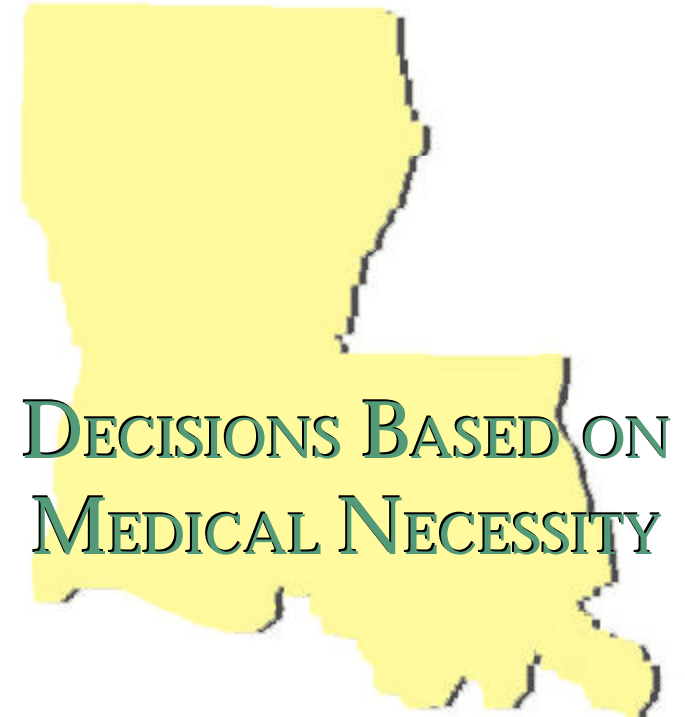
If you have questions on Louisiana's MNRO law or wish to file a complaint against a Louisiana-licensed MNRO, contact the Quality Assurance Division in the Office of Health Insurance, Louisiana Department of Insurance at (225) 219-8769.

You may also obtain additional information and download a copy of the complaint form at www.lidi.la.gov

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LOUISIANA DEPARTMENT OF INSURANCE OFFICE OF HEALTH INSURANCE



Medical Necessity Review Organization
(MNRO)

YOUR APPEAL RIGHTS
UNDER ACT 401

“WHAT IS MNRO?”

ACT 401 (REGULATION 77)

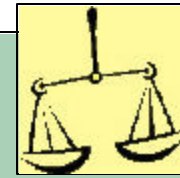
MNRO stands for Medical Necessity Review Organization. In 1999, the Louisiana Legislature passed Act 401, mandating the authorization or licensure of entities making medical necessity determinations as medical necessity review organizations (MNROs). This law provides for minimum standards for such organizations, so that all health plans follow the same standards in resolving disputes. Additionally, internal and external grievance procedures were established to appeal adverse medical necessity determinations.



WHAT CAN IT DO FOR ME?

If a patient or provider receives a notice that a health care service otherwise offered and payable under his policy is being denied because it is not medically necessary, then the covered person has a right to file an appeal with the health insurance issuer. The appeal process involves a two-level internal appeal and an external appeal, which is outlined here.

MNRO APPEAL PROCESS



❖ FIRST LEVEL INTERNAL APPEAL...

Requested by the covered person within 60 days of receiving the adverse determination. The MNRO has 30 working days following the request for appeal to notify in writing both the covered person and the provider of the decision.

❖ SECOND LEVEL INTERNAL APPEAL...

If the first level appeal decision upholds the denial, a second level appeal can be requested by the covered person within 30 days of receiving the first level appeal decision. The review panel must hold a review meeting within 45 working days of receiving the request for the second level review. The MNRO has five days following the completion of the review meeting to issue a written decision to the covered person.

❖ EXTERNAL REVIEW...

If the second level appeal decision upholds the denial, the covered person, **with the concurrence of the treating provider**, may request an external review within 60 days of receiving the second level appeal decision. The MNRO must provide any relevant information to the designated Independent Review Organization (IRO) within seven days after the receipt of the request for external review. The IRO shall provide notice of its recommendation to the MNRO, the covered person and the provider within 30 days after receiving the second level decision information.

❖ EXPEDITED INTERNAL APPEAL...

An expedited appeal can be requested when a denial involves a situation where the **time frame would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function**. In this case, the MNRO must make a decision and notify the covered person and/or provider as expeditiously as possible, but no more than 72 hours after the appeal is begun.

❖ EXPEDITED EXTERNAL REVIEW...

After receiving an adverse determination involving an emergency medical condition, the covered person's health care provider may request an expedited external review. Within 72 hours of receiving appropriate medical information, the IRO shall make a decision to uphold or reverse the denial and notify the covered person, the MNRO and the treating provider of the decision.

NOTE: For a more detailed explanation of the appeals process and to review items required in a MNRO's letter of adverse determination, visit our website at www.lldi.la.gov to review Act 401 and Regulation 77 regarding MNROs. Click on "LDI Office Index," then "Office of Health Insurance," and "Quality Assurance Division."